Bramalea Optometric Clinic

Dr. Susan Cooper, Dr. Marian Cotnam, Dr. Rima Mammo, Dr. Stephanie Lombardo

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WELCOME TO OUR OFFICE!

In order for us to provide you with a thorough examination, please answer all questions. Please print.

Date:_____

Surname:_____ First Name:_____ Miss/Master_____

Address:_____ City:_____ Postal Code:_____

Telephone #: Home:_____ Mom/Dad's Business/Cell:_____

☐ I give Bramalea Optometric Clinic permission to contact me/my guardian via email or text for appointment reminders and glasses or contact lens updates.

Cell:_____ e-mail:_____

Birthdate: Month_____ Day_____ Year_____

Health Card #:_____ Version Code:_____

How did you hear about our office?_____

Date of Last Eye Exam:_____ Last Eye Doctor:_____

Date of Last Medical Exam:_____ Family Doctor:_____

List any medications you are taking:_____

List any allergies you have:_____

FAMILY HEALTH AND OCULAR HISTORY—Please CIRCLE the appropriate answer.

	Self	**Family**		**Self**	**Family**
Diabetes	Yes/No	Yes/No	Lazy Eye (Strabismus)	Yes/No	Yes/No
High Blood Pressure	Yes/No	Yes/No	Glaucoma	Yes/No	Yes/No
Heart Trouble	Yes/No	Yes/No	Cataracts	Yes/No	Yes/No
Thyroid Disorder	Yes/No	Yes/No	Macular Degeneration	Yes/No	Yes/No
Other	_____				

Please list the reason for your eye examination today and any visual problems you are having:

_____

_____

_____

Do you wear glasses? Yes/No _____Fulltime ____Distance only ____Reading only

Do you wear sunglasses? Yes/No

Have you ever had eye surgery or an eye injury? Yes/No If yes, please describe:

_____

_____

Do you suffer from headaches or eyestrain? Yes/No

What grade are you in at school? _____

What school do you go to? _____

Where do you sit in your classroom? Front / Middle / Back

Are you experiencing any of the following:

Problems seeing the chalkboard / smart board? Yes / No

Difficulty reading? Yes / No

Reversing letters and / or numbers? Yes / No

What hobbies / activities are you involved in?